MIKE FOGARTY
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STATE, OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

November 1, 1999

Ms. Sally Richardson
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Richardson:

The State of Oklahoma is pleased to submit a response to your questions regarding our three-year extension request of the §1115(a) Research and Demonstration Waiver (Project No. 11-W-00048/6), pursuant to Section 4757 of the 1997 Balanced Budget Act.

We look forward to your response. If you have any questions or need additional information, please contact Matt Lucas at (405) 522-2723.

Sincerely,

Mike Fogarty,
Chief Executive officer
State of Oklahoma Medicaid Director

Cc: Art Pagan, HCFA Dallas Regional Office
Tammy Auseon, HCFA Dallas Regional Office
Joyce Jordan, HCFA Baltimore Central Office

oklahoma health care authority

Response to Questions 1 through 34 Regarding the Three-year §1115(a) Research & Demonstration Waiver Extension Request

November 1, 1999

Budget Neutrality

1. *Discuss trend rates during the extension period Please submit expenditure, member month and per member per month (PMPM) cost data for calendar years **1994** through **1998**. We would like to look at five years of expenditure and member month experience to determine what the recent Medicaid cost trend has been in Oklahoma. Since the extension request includes data on the Aid to Family with Dependent Children (AFDC) eligibility group for **1996, 1997,** and **1998**, it is only necessary to provide AFDC data for **1994** and **1995**. For the Aged, Blind, and Disabled (ABD) population, please submit data for all five years. The specification for the data should be similar to actual SoonerCare experience and the SoonerCare base year.*

Response:
Per the Health Care Financing Administration (HCFA) request the State is actively working on extracting eligible and expenditure information from 1994 through 1998 for the *SoonerCare* (**SC**) population. However, due to Year 2000 compliance requirements, extracting the data that meets the above specifications may take several weeks.

The preliminary information provided in Attachment A is not being provided in lieu of the requested information, but is being provided to give HCFA an idea of what the overall trends have been for the Medicaid population. All information was drawn from the State's 2082 reports and is based on a Federal Fiscal Year (FFY), with the exception of the capitation payments, which are drawn from the State's Annual Budget Neutrality Reports that are based on a Calendar Year. Attachment A contains the following information:

Attachment A - Page 1:
Per Member Per Month Costs & Percentage Change from the Previous Year for 1994 through 1998.

Attachment A - Page 2:
Unduplicated Eligible and Expenditure information for FFY-1994 through FFY-1998.
Unduplicated Eligible and Expenditure Percentage Trends for FFY-1994 through FFY-1998.

Attachment A - Page 3:
Unduplicated Eligible Count and Percentage Change from the Previous Year.
Expenditures and Percentage Change from the Previous Year.

2. *The CY **1998** PMPM cost, as calculated from actual expenditures, is less than that for **1997**. SoonerCare expenditures include fee-for-service (FFS) as well as prepaid payments to **MCOs**. **Is** the FFS data for **1998** complete? **Is** the reduction from **1997** to **1998 final** or could it change given more time for claims to come in?*

Response:
Based on a preliminary assessment of the §1115(a) Research & Demonstration Waiver (R&D) eligible member months and expenditures for 1997 and 1998 the reduction in Per

Member Per Month (PMPM) costs appears to be the direct result of the State's Title XXI/Senate Bill 639 (S.B. 639) eligibility expansion.

On January 15, 1998 the Governor signed Oklahoma's Title XXI State Children's Health Insurance Plan Application. This application proposes using Title XXI funds to expand Medicaid coverage. This option, for Oklahoma, is available for children who do not qualify for Medicaid under State rules in effect as of April 15, 1997. Under this option current Medicaid rules would apply. The application was approved by the Health Care Financing Administration on May 5,1998 with an effective date of December 1,1997.

Prior to the enactment of the new Children's Health Insurance Program under the Balanced Budget Act of 1997, Oklahoma recognized the need to establish a coordinated approach to delivering quality health care services to under-served/uninsured populations (specifically children and pregnant females). Accordingly, S.B. 639 was enacted during the State's 1997 Legislative Session. This law expanded Medicaid eligibility through the State's ***SoonerCare*** *(SC)* program. It required the Oklahoma Health Care Authority (OHCA) to expand Medicaid eligibility for pregnant females and for children born on or after October 1, 1983. This includes those persons with annual incomes up to one-hundred-eighty-five (185%) percent of the Federal Poverty Level (FPL). This expansion became effective December 1, 1997. The bill further directed the OHCA to include in this expansion those children born prior to October 1, 1983, who have not yet reached their eighteenth (18th) birthday, and who are due to be phased into Oklahoma's Medicaid Program according to existing Federal requirements.

The expenditure data in question is reported on a date-of-payment basis (per HCFA's instructions) and so, by definition, is complete for both years. However, the slight drop in PMPM values from 1997 to 1998 ($123.19 to $121.98, a 0.9% decrease) does not represent medical deflation, but instead was due to changes in the mix of *SC* members.

Oklahoma in 1998 began aggressive enrollment into its Children's Health Insurance Program (CHIP), under the Medicaid expansion option. CHIP enrollees, as Medicaid beneficiaries, are also *SC* eligibles and are enrolled into MCOs in urban areas and the PCP/CM program in rural areas. The outreach efforts associated with this expansion brought in new eligibles as well as individuals that were eligible prior to the expansion but were not enrolled. **As** a result of the State's aggressive outreach campaign the Medicaid program experienced a 12% increase in eligible member months from CY-1997 to CY-1998.

Young children and adolescents are the least costly group, on a per member per month basis, in ***SC.*** Therefore, as the portion of total *SC* enrollment comprised of children and adolescents rose in 1998, average PMPM costs fell. If the member mix had stayed constant from 1997 to 1998, the average PMPM capitation payments to MCOs would actually have risen by approximately 7.5%, the overall rate increase.

Unlike many other states, Oklahoma largely achieved its CHIP enrollment objectives in 1998. The State therefore believes that its non-ABD member profile has re-stabilized and that medical inflation will have resumed in 1999.

3. *The provisions of the Balanced Budget Act, which provide for extending the duration of State Health Reform Demonstrations, requires us to assess the State's performance under the Special Terms and Conditions. There is special emphasis on performance under budget neutrality. An essential report for HCFA's assessment of budget neutrality is the form HCFA-64.9 waiver supplement. There is a concern about the completeness of the expenditures reported on the waiver supplements. Oklahoma is currently in the process of correcting their waiver supplements. Please provide a process and timeline for the correction of problems with reporting expenditures on the form HCFA-64.9 waiver supplement. Also, HCFA will identify formatting problems on the waiver supplements and work with the State to correct them.*

   Response:
   Due to continuing systems issues, the State is unable at this time to provide HCFA with a completion date for the correction of the HCFA-64.9 supplement. However, the OHCA is currently working on extracting quarterly *SC* expenditure data to send with the report until the systems problem can be addressed by our fiscal agent. The quarterly reports will contain expenditure information, by date of service and by date of payment, going back to January 1996. The State expects to have the reports available to HCFA no later than December 13, 1999. Furthermore, the State will continue to submit these quarterly expenditure attachments with the HCFA-64.9 until the systems problems are corrected.

4. *In Attachment A, it shows Oklahoma's SoonerCare expenditures of $852 million for the first three years, however, HCFA's assessment of the waiver supplements indicates about $215 million. Please provide an explanation for this discrepancy.*

   Response:
   Attached you will find a copy of the HCFA-64.9s for the first three years of the waiver. The reports, number 17(E), show total managed care waiver expenditures of $323,350,783 (see Attachment B) which consist of capitation/supplemental payments. There is an additional $529,295,194 million in FFS expenditures for this group. The FFS expenditures for the *SC* group are not being reported on the correct line item of the report. Oklahoma continues to work on generating HCFA-64.9 and/or 64.9p reports that are consistent with the requirement outlined in the Special Terms and Conditions. Additionally, we are in the process of preparing quarterly expenditures reports for 1996 through 1998 to supplement the HCFA-64.9 information. The reports will be completed no later than December 13, 1999.

5. *On page 3 of the Budget Neutrality Report for Waiver Year Three (June 30, 1999), it lists five categories of expenditures, which include FFS claims, capitation payments, Graduate Medical Education Payment Adjustments and Prescription Rebate Adjust. which of these categories are being excluded from the waiver supplements? Are there additional payment categories, such as payments for deliveries and to MCOs for delivery services performed by residents that should be added to the waiver supplement reports?*

Response:
FFS claims and Prescription Rebate Adjustments are not included in the waiver supplements. As stated earlier the FFS expenditures for the *SC* group is not being reported on the correct line item of the report (refer to questions 3 and 4).

HMO capitation rates are established net of prescription rebate dollars, thereby making it unnecessary to adjust expenditures for the AFDC-Related *SC Plus* population to account for rebates. However, the State still pays pharmacy claims for the *SC Choice* AFDC-Related population on a fee-for-service basis. To account for estimated rebate dollars (which are not tracked separately for AFDC-Related *SC Choice* clients), the State has reduced total expenditures for the *SC Choice* population by one percent'.

Year Three supplemental payments, newborn settlement payments, delivery payments, resident delivery payments, and resident primary care physician payments are included in the 1998 MCO capitation payments (see Attachment C for detailed information).

6. *The original Terms and Conditions stated that co-payments were to be instituted for the medically needy populations. Have individuals from this population been enrolled under the waiver? And if so, how have the co-payments been taken into consideration in the budget neutrality calculations?*

Response:
The medically needy population has not been enrolled under the waiver, and co-payments have not been instituted for this population under the State's FFS program.

FQHCs

7. *The State has submitted a proposal to HCFA to modify the methodology by which it reimburses FQHCs. HCFA has indicated to the State that the proposed methodology will not be approved and recommended that the State consider reimbursing at 100% of cost. The State has agreed to submit a withdrawal by mid-October for the amendment and submit a protocol amendment to pay up to 100% of the FQHC cost. Therefore, all references to the supplemental payments should be removed from the extension. Please provide a timeline as to when the protocol amendment will be submitted to HCFA.*

Response:
Section (I) Federally Qualified Health Centers, number 1 on page 11, has been modified to exclude all language as it relates to the introduction of a new supplemental payment program for the FQHCs (see Attachment D for replacement page).

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[1] **One Percent Calculation: The expenditure totals are adjusted downward by one percent to account** for **State prescription rebate dollars. Oklahoma does not track rebates by** MEG **and** so **the adjustment is an estimate. It was derived by dividing base year prescription rebate dollars into total Medicaid expenditures across all** MEG's.

The state is currently drafting an amendment to the protocol, for the new supplemental payment program, with a proposed submission date of November 20, 1999.

Access to Care

8. *The CAHPS data on page 15 indicate that 44 percent of adults reported receiving care without long waits. Is the assumption that 56% of adults receive care with long waits? Please explain.*

Response:
Please refer to page 16, paragraph one of the Waiver Extension request for a detailed explanation.

9. *The satisfaction ratings for customer service seems lower compared to the other categories listed on pages 16 and 15. Please describe ways the State has considered to improve customer services.*

Response:
The State is focusing on improving customer service capabilities, and the increase in satisfaction with customer services indicated is one of the greatest improvements documented in the survey data. This indicates that health plans are adequately addressing these needs without State directed intervention. The State and the health plans have worked toward assisting Medicaid recipients in navigating the managed care system. The improvement indicates the success of these efforts.

10. *What were the CAHPS results to access and experience with specialist services?*

Response:
Please refer to quarterly report April through June 1999, section V. D. and Attachment 2 of this report for the full CAHPS technical report. Access to, and experience with specialists is not a CAHPS combined reporting item. Individual items on specialist services are included in Attachment E.

11. *What steps has the State considered to continue the improvement as shown on page 21 in the rate of first trimester initiation of prenatal care as well as EPSDT and immunization rates?*

Response:
Focused studies released recently show first trimester initiation of prenatal care to be at 51% indicating a continued increase. Since pregnancy is a condition of eligibility for Medicaid, the actual initiation of prenatal care frequently occurs before enrollment in the Medicaid program. The State continues an active outreach effort in collaboration with other State

agencies.
EPSDT rates from recently released focused studies indicate continued increases across all health plans. Current rates are from 50 to 73 %. The State and health plans continue to aggressively work toward the target rate of 80%.

12. How does the State determine medical necessity?

Response:
The health plans determine medical necessity for the ***SC** Plus* population, however, the OHCA provides the health plans and the Primary Care Provider/Case Managers (PCP/CMs) in the ***SC** Choice* areas with a standard benefit package for all individuals enrolled in these programs. Individual determination of medical necessity is made based on covered services and the needs of the eligible recipient enrolled in the program. All SC contracts, approved by HCFA, include the State's definition of medical necessity, as well.

13. The State has noted on page 6 a pilot program that would enroll the long-term care population and/or Medicaid/Medicare dual eligibles into fully integrated systems of care. Since no amendments or changes can be made through the extension, all references to the pilot program should be removed from the extension.

Response:
Number 1.7, the last paragraph, on page **6**, has been modified to exclude all language as it relates to the introduction of a long-term care pilot program (see Attachment **F** for a replacement page).

Indian Health Services

***14.** The State, on page 10, indicates that it has received a request from tribal and IHS programs to work with them to develop a model, which would allow them to serve as PCP/CMs in the SoonerCare program. Please provide further information about the development of this model; What are the State's immediate plans for involving tribal input?*

Response:
Under the current ***SC** Choice* contract, Primary Care Providers employed by tribal health care systems or the Indian Health Service (IHS) can participate as PCP/CMs. They can participate under the same terms and at the same payment rate as any other provider. However, beginning October 1998, the State was approached by representatives from several tribes interested in exploring the possibility of participating as PCP/CMs under an arrangement, which would maintain their current level of reimbursement. During subsequent months, ***SC** Choice* staff met with representatives from various tribes including Choctaw Nation, Chickasaw Nation, Kickapoo Tribe, Citizens of Potawatomi Nation, Cherokee Nation, Wyandotte tribe and IHS to obtain their input. Through this dialogue, the State

developed a unique Primary Care Case Management model for tribal and IHS providers. At this time the contract is in draft format. However, it is anticipated that it will be ready for pilot implementation within the next few months. A copy of the draft contract will be forwarded to HCFA for approval, prior to implementation.

15. *The IHS programs have experienced problems in the past when an IHS physician would make a medical referral for the patient to see a specialist and the MCO physician would disagree with the need for a referral. This situation may place a patient in a difficult position and result in the patient not seeing a specialist for their medical problem. Has the State experienced this type of problem? If yes how does the State resolve this problems?*

Response:
Indian Health providers are located in all three ***SC Plus*** service areas. Under the self-referral option, Native American members can utilize these facilities or their MCO. Staff at the Native American clinics has access to ***SC Plus*** member service and administrative staff whom they can contact for assistance in the resolution of these issues. The ***SC*** Helpline also specifically tracks these types of issues and reports them to ***SC Plus*** staff on a daily basis.

Upon notification, by the IHS facility, ***SC Plus*** staff contact the health plan and makes arrangements for the member to visit their PCP's office for an assessment. If the member's PCP and/or health plan still do not agree with the specialty referral, OHCA member service staff assists the member in the filing of an appeal with the health plan. If the health plan appeal process concludes without successful resolution, the case is remanded to OHCA for appeal to the administrative law judge, the OHCA Medical Director and finally the CEO of the Health Care Authority.

Quality Monitoring

16. *The CAHPS data on page **15** indicate that **29% of** adults reported not being able to get care when needed Although it represents a marked decrease from the previous year, this percentage still seems high. What steps has the State taken to address this problem?*

Response:
The National CAHPS Benchmarking database reports a National Medicaid benchmark of **62%** for this item for the first reporting year. Year two data are not currently available. Based on available national data for this item, the percentage indicated does not seem high. However, the State will continue to work with recipients and health plans to improve recipient perception of getting care when needed.

1% *The State indicated on page **12** that the volume of encounters submitted by the **MCOs** remains below the anticipated volume. What measures is the State undertaking in addition to those mentioned, to improve encounter data reporting among the **MCOs?***

Response:
OHCA has instituted mandatory monthly encounter data coordination meetings with the health plans. Within that forum, OHCA provides monthly status reports to the health plans as to the success of their encounter submission efforts. OHCA also utilizes this forum to educate the health plans about issues that are affecting their encounter data submission efforts. Since the institution of these meetings all of the plans have become complaint in the area of encounter data submissions.

18. How do SoonerCare Plus and Choice providers identify children with special health care needs? What categories do the provider use?

Response:
Beginning in July 1999, the ***SC Plus*** program began transitioning those individuals categorized as Aged, Blind, and Disabled into managed care. The top ten percent of this population, which included children with special health care needs, were identified by the State based on utilization information. Because these individuals, referred to as SP/ABDS (special programs/ aged, blind, disabled) were high utilizers of services based on past history, special attention was given to them to assist them with the transition into managed care. Our medical/professional unit on three separate occasions telephoned the individuals to complete a medical profile that was forwarded to the health plan and the SC ***Plus*** staff personally assisted the member with a health plan selection. We implemented a staggered enrollment period that allowed the members to enroll July through October and each month sent a list to the Exceptional Needs Coordinators (ENCs) at each health plan. The ENCs were expected to initiate a treatment plan for all SP/ABDs within 10 days of their effective date with that health plan. This includes assisting with a PCP selection, forwarding the medical profile to the PCP and assuring that an appointment is scheduled within the first thirty days of plan selection. The ***SC Choice*** Program which is just beginning to transition this population into managed care has also identified the high utilizers of services and outbound calling and completion of medial profile is underway, and will be forwarded to their PCP. Lists of identified SP/ABDs will be distributed to each provider representative to help with PCP selection.

In Year VI, ***SC Plus*** is looking at placing an identifier on the monthly roster that will be forwarded to the health plan each month. Several methods for identification of special needs children are being explored. The main focus centers on utilization of services, identification of certain chronic diagnoses or multiple diagnoses, and medical conditions that have persisted or are expected to persist for at least 12 months. Plans include looking at both the TANF and ABD populations possibly, if warranted, separating this population out and designing a separate benefit package. Depending on our identification method and how the cost analysis presents, an additional case management fee may be looked at or a capitation rate adjustment for this group may be appropriate.

19. Please explain any special processes and procedures on enrollment/disenrollment with respect to children with special health care needs?

Response:
As explained in question number 18 above, all of the SP/ABD group received personal counseling by OHCA staff to assist members with aligning themselves with a health plan that allowed the transition into managed care to be as disruptive as possible ***SC Plus*** allowed members during the staggered enrollment period to adjust their selections to align them with their current providers. ABD members were allowed to appeal their transition into managed care if they desired and for those who did not meet the criteria for exclusion special counseling was given to assist families with a health plan selection. In Year VI, we expect to be able to have a health indicator on each case so that special needs children can easily be identified and aligned with the services that are deemed medically necessary for them.

20. Please explain how the State evaluates primary care and hospital capacity as well as the range of other specialized services including pediatric sub-specialists, hospitals specializing in the care of children, ancillary therapists, mental health and substance abuse professionals, and home health care providers.

Response:
We utilize a GeoAccess program to evaluate all types of reported health plan networks. Contractual requirements for the health plans include submitting monthly updates to their provider networks. Compliance with provider requirements is evaluated at the yearly health plan response to the request for proposal, health plan readiness reviews and yearly compliance audits. Access to provider issues is monitored on a daily basis through our incident reporting process from our enrollment agent and through direct member complaints through OHCA.

21. What steps is the State taking in strengthening both the medical home for children with chronic conditions as well as the range of special health services that these children require?

Response:
In February 1999, the Department of Human Services, the agency responsible for determining member eligibility, began a new procedure that removed the closure of cases after their six months of eligibility had expired. Prior to February, members automatically had their cases closed if the six months period expired and they failed ***to*** have their case re-certified. The removal of the case closure has allowed the members to remain with their existing health plan and/or provider until their case could be re-certified, rather than falling back into the traditional **FFS** program.

22. Please clarify whether the set of access standards mentioned addresses specialist or chronic care.

Response:
No, these standards address access to primary care providers.

23. *Do children with special health care needs have access to providers including specialists that are experienced in caring for this population?*

Response:
In Year *V*, ***SC*** *Plus* expanded the required specialist types to include, pediatric specialist and pediatric sub-specialists. Health plans were also asked to have developmental pediatric providers included as a specialty care provider requirement. All other categories of providers caring for children with special or chronic needs were required in previous years. Approximately **67%** of all providers that were treating our **ABD** members when they were in traditional fee-for-service Medicaid are currently contracted with one or more of our participating health plans.

24. *Are all medically necessary specialty services provided within the* ***MCOs*** *network for children with special health care needs?*

Response:
Yes, all medically necessary specialty services are provided within the MCO's network. In cases where the network provider has been located at such a distance that a referral was inconvenient or presented issues for the member/ family, it has been our experience that our MCO's would consider a referral to an out-of-network specialist, if needed.

25. *Please provide information on the State's new program with the Oklahoma State Department of Education for enhanced EPSDT school based services. Does this program provide additional preventive care services for does it establish a financing and coordination mechanism for health-related special education and early intervention services? What system(s) does the State have in place to prevent any duplication of payments*?

Response:
The State's school based services program is in its seventh year. Approximately three years ago the state added some additional services after collaboration between OHCA, the State Department of Education and some local school districts. This program allows financing and coordination mechanisms for health-related service as well a providing preventative and early intervention.

Coordination of care is a contractual obligation for the school districts. The RFP also designates services pursuant to an IEP, IHSP, IFSP or 504 Accommodation Plan as wrap-around services for health plans. In addition there is a cost recovery for screening services provided out of plan.

26. Except for EPSDT, no other service utilization data is presented in the waiver application. Which of the HEDIS utilization measures does the State require? For children with special needs, it is particularly important to monitor both EPSDT and other ambulatory care services, dental services, pharmacy services, outpatient and inpatient mental health and substance abuse services and hospitalizations. How does the State monitor these services?

Response:
The State requires all of the identified Medicaid HEDIS measures. Ambulatory care services, dental services, pharmacy, outpatient, inpatient, mental health substance abuse services and hospitalizations are all HEDIS measures and are required to be submitted. The State has submitted these measures to HCFA previously, in its quarterly and yearly waiver reports, and will continue to update them as received.

Persons Living with HIV/AIDS

27. How will the State ensure that beneficiaries have access to providers including specialists that are experienced in caring for persons living with HIV/AIDS?

Response:
OHCA participates in a statewide HIV Consortium and Managed Care Transitions is a special Ad hoc committee that was formed to educate providers/consumers across the state. Prior to the ABD implementation, the Health Care Authority conducted training for current HIV providers, caregivers, and case managers in the urban areas about the transition. In cooperation with this group, current Medicaid recipients with HIV have been identified and aligned with providers that traditionally have been serving this population. In most cases, the specialists that are located in Oklahoma City and Tulsa that these members have been seeing, are contracted with most of our plans. Because we have specified that the health plans grant 'standing referrals', most members can continue to see their specialists as much as is medically necessary. The case management process for persons with HIV is being monitored through monthly meetings with the Exceptional Needs Coordinators (ENCs) and to date, there have been no trending issues for this group.

28. Does the State plan to establish a separate capitation rate for people living with HIV/AIDS or consider other forms of risk adjustment?

Response:
Even though the expected number of persons living with WIV in the urban areas of Oklahoma was low (approximately 100) we explored a separate capitation rate for persons with HIV in Year V. There was nothing in our utilization data to warrant different rates. Through a grant with HRSA, the HIV consortium and OHCA are exploring risk sharing and cost containment strategies by studying other states.

29. How will the State address payment of antiretroviral medications? Will they be carved out of the capitation rate?

Response:
It is too early to analyze any data at this point, or to realize any excess prescription costs for this population. Due to the small number of persons with HIV that are eligible for Medicaid, it is doubtful that antiretroviral medications will be carved out of the capitation rate. Because, costly prescriptions for persons with HIV in traditional fee-for-service Medicaid were limited to three per month, the State will re-evaluate the real costs of these medications.

30. Has the State worked with the Ryan White Care Act providers in the State in the process of deciding to include the SSI population in the waiver, and in system changes that may be necessary to accommodate people living with HIV?

Response:
As stated in Question 27, the OHCA is affiliated with the HIV Consortium, which also includes members from the State Department of Health, which monitors Ryan White funding and the two Ryan White programs in the state. Through our five public meetings with advocates/consumers, providers prior to the release of our Year V RFP, members from both Ryan White programs along with their contracted caregivers were active and provided input about the transition of this group. Once the provider alignments were realized, the transition has been very successful.

31. Has the State considered any quality of care monitoring studies specific to people living with HIV/AIDS?

Response:
In Year V, the health plans are required to conduct two (2) quality of care studies that are specific to the ABD population. While a focused study on HIV was not mandated, HIV was a suggested recommendation.

Homeless

32. How does the State ensure that plans have an appropriate range and level of experience/expertise in providing clinical and support services to homeless individuals?

Response:
In Year V with the transition of the ABDs, OHCA required the health plans to employ ENCs. The role of the ENCs is to act as the point person or patient advocate for members as well as to be able to refer any member to community resources or services that fall outside of the health plan benefit package. OHCA has provided training sessions for the ENCs at each monthly meeting to help them connect with resource opportunities within the community. Additionally, OHCA has entered in to an interagency agreement with OASIS, a statewide

information and referral network and will work with them to expand their existing database. Through the agreement, the database will be available to each of the health plans. Beginning in December, a training and health grant from the Developmental Disabilities Council will focus on communication skills and community resource sharing. OHCA has conducted training with each of the Department of Human Services urban county offices to establish a link between Adult Protective Services (APS) unit and the health plans. Because APS work closely with the homeless, they often are responsible for linking that population with appropriate medical care.

33. Does the State require plans to develop linkage agreements with homeless service providers including specialists to facilitate the delivery of Medicaid and non-Medicaid medical and social services?

Response:
The State requires each health plan to contract with at least one Federally Qualified Health Center (FQHC) in each service area and they must negotiate in good faith with all Essential Community Providers, including Community Mental Health Centers, that request a contract. All members that the health plan is unable to contact within 90 days of continuous enrollment will be assigned to an FQHC.

Furthermore, ***SC Choice*** provides services for all eligible rural recipients, including "homeless" members through the regular enrollment, outreach and delivery mechanisms. ***SC Choice*** contracts with all Federally Qualified Health Centers in the State which typically provide services to this "at risk" population. Additionally, the state works directly with Healing Hands Clinic, an FQHC satellite facility, which primarily serves the homeless population, to provide services to the homeless ***SC Choice*** members. Members who present for care at Healing Hands are encouraged to change their PCP/CMs to a provider at the clinic to facilitate their care until such time **as** they return to their own community. To ensure access to for this population, ***SC Choice*** does not auto assign additional patients to the clinic. All contracted capacity is for ***SC Choice*** eligible recipients who are homeless.

34. Please describe how the enrollment and auto-assignment processes address the special enrollment needs of homeless individuals. If a homeless person fails to choose a plan during the enrollment process, what steps are taken to identify the usual source of care and then assign the beneficiary to a plan that includes this provider in its network?

Response:
Intensive efforts were undertaken to try and reach every ABD member to encourage selection of a health plan. Because the population has a tendency to either move frequently or not establish a permanent home, these members were difficult to locate. OHCA retrieved the most recent claims history information to attempt to locate the most recent address or provider. Multiple calling attempts, written correspondence, enrollment fairs, face-to-face-home visits, etc., were completed. After the staggered enrollment period for the ABD transition, members who had not selected a health plan were auto assigned to plan. OHCA,

along with the monthly member roster, sent the most recent provider information to each of the assigned health plans. This information helped to link those members with the providers that were traditionally serving the member and to assure service continuation for any medically necessary service that had been prior authorized by the State to continue for the first thirty days of transition into managed care.

Attachment A, *page 1*

Per Member Per Month Costs and Percentage Change from the Previous Year for FFY-1994 through FFY-1998

	1994 PMPM Cost	1994 Change from Previous Year	1995 PMPM Cost	1995 Change from Previous Year	1996 PMPM Cost	1996 Change from Previous Year	1997 PMPM Cost	1997 Change from Previous Year	1998 PMPM Cost	1998 Change from Previous Year	Total Change For All Years
Aged	$481.08	-	$512.25	0.06	$540.18	0.05	$611.88	0.13	$660.07	0.08	**0.33**
Blind	$221.67	-	$238.48	0.08	$218.37	(0.08)	$253.24	0.16	$359.21	0.42	**0.57**
Disabled	$494.71	-	$521.54	0.05	$542.08	0.04	$573.72	0.06	$663.29	0.16	**0.31**
Total	***$486.14***	**-**	***$515.28***	***0.06***	***$539.05***	***0.05***	***$588.40***	***0.09***	***$660.03***	***0.12***	**0.32**
AFDC-Child.	$76.99	-	$83.36	0.08	$74.02	(0.11)	$61.41	(0.17)	$62.79	0.02	**(0.18)**
AFDC-Adults	$71.13	-	$72.18	0.01	$57.40	(0.20)	$46.24	(0.19)	$71.06	0.54	**0.15**
Crtk/Prg Wm	$142.12	-	$134.00	(0.06)	$106.62	(0.20)	$95.61	(0.10)	$91.63	(0.04)	**(0.41)**
Others	$23.33	-	$23.51	0.01	$19.39	(0.18)	$27.74	0.43	$27.32	(0.02)	**0.25**
Cap. Pymts.	$0.00	-	$0.05	1.00	$37.25	809.67	$43.04	0.16	$50.07	0.16	**810.99**
Total	***$81.75***	**-**	***$85.74***	***0.05***	***$95.84***	***0.12***	***$90.51***	***(0.06)***	***$97.55***	***0.08***	**0.19**

Note: The State of Oklahoma began making capitation payment under the 1115(a) waiver in January 1996, this accounts for the significant percentage increase which occurred in 1996 (please note that the overall increase for this year is !2%). Additionally, all expenditures and eligible months are based on a Federal Fiscal Year, with the exception of capitation payments, which are based on a State Fiscal Year.

Attachment A, *page 2*

Unduplicated Eligible and Expenditure Information for FFY-1994 through FFY-1998

	1994 Eligibles	1994 Expenditures	1995 Eligibles	1995 Expenditures	1996 Eligibles	1996 Expenditures	1997 Eligibles	1997 Expenditures	1998 Eligibles	1998 Expenditures
Aged	53,154	$306,857,339	52,256	$321,218,668	50,390	$326,637,034	49,550	$363,826,138	49,808	$394,519,268
Blind	802	$2,133,330	789	$2,257,934	762	$1,996,788	713	$2,166,729	690	$2,974,226
Disabled	56,082	$332,930,632	60,114	$376,225,030	61,747	$401,664,843	62,959	$433,451,444	63,251	$503,443,450
Total	***110,038***	***$641,921,301***	***113,159***	***$699,701,632***	***112,899***	***$730,298,665***	***113,222***	***$799,444,311***	***113,749***	***$900,936,944***
AFDC-Child.	238,395	$220,255,274	243,399	$243,467,088	230,654	$204,868,658	223,836	$164,947,248	250,289	$188,591,318
AFDC-Adults	66,339	$56,623,118	64,932	$56,244,658	58,698	$40,432,561	51,379	$28,512,223	47,607	$40,595,394
Crtk/Prg Wm	32,169	$54,860,881	33,942	$54,577,066	34,863	$44,605,890	37,717	$43,274,604	41,761	$45,916,491
Others	1,746	$488,725	3,126	$881,932	4,457	$1,037,143	5,559	$1,850,487	6,164	$2,020,770
Cap. Pymts.	-	$0	-	$100,429	-	$87,063,067	-	$107,348,077	-	$127,709,039
Total	***338,649***	***$332,227,998***	***345,399***	***$355,361,173***	***328,672***	***$378,007,319***	***318,491***	***$345,932,639***	***345,821***	***$404,833,012***
Grand Total	**448,687**	**$974,149,299**	**458,558**	**$1,055,062,805**	**441,571**	**$1,108,305,984**	**431,713**	**$1,145,376,950**	**459,570**	**$1,305,769,956**

Unduplicated Eligible and Expenditure Percentage Trends for FFY-1994 through FFY-1998

	1994 Elig. % Change From Previous Yr.	1994 Expend. % Change From Previous Yr.	1995 Elig. % Change From Previous Yr.	1995 Expend. % Change From Previous Yr.	1996 Elig. % Change From Previous Yr.	1996 Expend. % Change From Previous Yr.	1997 Elig. % Change From Previous Yr.	1997 Expend. % Change From Previous Yr.	1998 Elig. % Change From Previous Yr.	1998 Expend. % Change From Previous Yr.
Aged	-	-	(0.02)	0.05	(0.04)	0.02	(0.02)	0.11	0.01	0.08
Blind	-	-	(0.02)	0.06	(0.03)	(0.12)	(0.06)	0.09	(0.03)	0.37
Disabled	-	-	0.07	0.13	0.03	0.07	0.02	0.08	0.00	0.16
	-	-	***0.03***	***0.09***	***(0.00)***	***0.04***	***0.00***	***0.09***	***0.00***	***0.13***
	-	-	0.02	0.11	(0.05)	(0.16)	(0.03)	(0.19)	0.12	0.14
	-	-	(0.02)	(0.01)	(0.10)	(0.28)	(0.12)	(0.29)	(0.07)	0.42
	-	-	0.06	(0.01)	0.03	(0.18)	0.08	(0.03)	0.11	0.06
	-	-	0.79	0.80	0.43	0.18	0.25	0.78	0.11	0.09
	-	-	-	1.00	-	456.1	-	0.23	-	0.19
	-	-	***0.02***	***0.07***	***(0.05)***	***0.06***	***(0.03)***	***(0.08)***	***0.09***	***0.17***
Grand Total	-	-	**0.02**	**0.08**	**(0.04)**	**0.05**	**(0.02)**	**0.03**	**0.06**	**0.14**

Attachment A, *page 3*

Unduplicated Eligible Count and Percentage Change from the Previous Year

	1994 Eligibles	1994 Change From Previous Year	1995 Eligibles	1995 Change From Previous Year	1996 Eligibles	1996 Change From Previous Year	1997 Eligibles	1997 Change From Previous Year	1998 Eligibles	1998 Change From Previous Year
Aged	53,154	-	52,256	(0.02)	50,390	(0.04)	49,550	(0.02)	49,808	0.01
Blind	802	-	789	(0.02)	762	(0.03)	713	(0.06)	690	(0.03)
Disabled	56,082	-	60,114	0.07	61,747	0.03	62,959	0.02	63,251	0.00
Total	***110,038***	-	***113,159***	***0.03***	***112,899***	***(0.002)***	***113,222***	***0.003***	***113,749***	***0.005***
AFDC-Child.	238,395	-	243,399	0.02	230,654	(0.05)	223,836	(0.03)	250,289	0.12
AFDC-Adults	66,339	-	64,932	(0.02)	58,698	(0.10)	51,379	(0.12)	47,607	(0.07)
Crtk/Prg Wm	32,169	-	33,942	0.06	34,863	0.03	37,717	0.08	41,761	0.11
Others	1,746	-	3,126	0.79	4,457	0.43	5,559	0.25	6,164	0.11
Total	***338,649***	-	***345,399***	**0.02**	***328,672***	***(0.05)***	***318,491***	**(0.03)**	***345,821***	***0.09***
Grand Total	**448,687**	-	**458,558**	**0.02**	**441,571**	**(0.04)**	**431,713**	**(0.02)**	**459,570**	**0.06**

Expenditures and Percentage Change from the Previous Year

	1994 Expenditures	1994 Change From Previous Year	1995 Expenditures	1995 Change From Previous Year	1996 Expenditures	1996 Change From Previous Year	1997 Expenditures	1997 Change From Previous Year	1998 Expenditures	1998 Change From Previous Year
Aged	$306,857,339	-	$321,218,668	0.05	$326,637,034	0.02	$363,826,138	0.11	$394,519,268	0.08
Blind	$2,133,330	-	$2,257,934	0.06	$1,996,788	(0.12)	$2,166,729	0.09	$2,974,226	0.37
Disabled	$332,930,632	-	$376,225,030	0.13	$401,664,843	0.07	$433,451,444	0.08	$503,443,450	0.16
Total	***$641,921,301***	-	***$699,701,632***	***0.09***	***$730,298,665***	***0.04***	***$799,444,311***	***0.09***	***$900,936,944***	***0.13***
AFDC-Children	$220,255,274	-	$243,467,088	0.11	$204,868,658	(0.16)	$164,947,248	(0.19)	$188,591,318	0.14
AFDC-Adults	$56,623,118	-	$56,244,658	(0.01)	$40,432,561	(0.28)	$28,512,223	(0.29)	$40,595,394	0.42
Crtk/Prg Wm	$54,860,881	-	$54,577,066	(0.01)	$44,605,890	(0.18)	$43,274,604	(0.03)	$45,916,491	0.06
Others	$488,725	-	$881,932	0.80	$1,037,143	0.18	$1,850,487	0.78	$2,020,770	0.09
Cap. Pymnts.	$0	-	$190,429	1.00	$87,063,067	456.19	$107,348,077	0.23	$127,709,039	0.19
Total	***$332,227,998***	-	***$355,361,173***	***0.07***	***$378,007,319***	***0.06***	***$345,932,639***	***(0.08)***	***$404,833,012***	***0.17***
Grand Total	**$974,149,299**	-	**$1,055,062,805**	**0.08**	**$1,108,305,984**	**0.05**	**$1,145,376,950**	**0.03**	**$1,305,769,956**	**0.14**